

**MEDICAL BOARD OF CALIFORNIA**

**CENTRAL COMPLAINT UNIT**  
**1426 Howe Avenue, Suite 54**  
**Sacramento, CA 95825-3236**  
**(916) 263-2424 FAX (916) 263-2435**  
<http://www.caldocinfo.ca.gov>

**REPORT OF SETTLEMENT, JUDGMENT OR ARBITRATION AWARD**

Required by Section 801.01 California Business and Professions Code

**PLEASE CHECK THE APPROPRIATE BOX:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Section 801.01 (b)(1) (Insurance Company)         | <input type="checkbox"/> Section 801.01 (b)(2) (Self-insured)  | <input type="checkbox"/> Plaintiff Attorney (Section 801.01 (e)) |
| <input type="checkbox"/> Section 801.01 (b)(3) (State or Local Government) | <input type="checkbox"/> Section 801.01 (c) (Employer-Prof. Corp., group practice, health care facility or clinic) |  |

**\*\*\*\*PLEASE PRINT OR TYPE\*\*\*\*****REPORTING ENTITY:**

- |                                    |            |
|------------------------------------|------------|
| 1. Company Name                    | 3. Address |
| 2. Name of Person Preparing Report | Telephone  |

**PHYSICIAN/PROVIDER:**

- |  |                                 |
|--|---------------------------------|
| 4. Name  | 5. License Number               |
| 7. Address(es)   | 6. Specialty/subspecialty       |
| 8. Defense Counsel Name  | 9. Defense Counsel Phone Number |
| 10. Address  |                                 |
| 11. NOTE: On reverse, enter full name(s), license numbers and specialty of other physicians, podiatrists or physicians assistants against whom a settlement (over \$30,000), a judgment or arbitration award (any amount) was rendered. Enter the amount paid and the type of the award paid on behalf of each provider. |                                 |

**PLAINTIFF/CLAIMANT:**

- |   |                                      |
|---|--------------------------------------|
| 12. Name  | 13. Address                          |
| 14. Relationship to patient   |                                      |
| 15. <u>Patient</u> Name   |                                      |
| 16. <u>Patient</u> Date of Birth                                      | 17. Medical Record Number            |
| 18. Deceased <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. <u>Specific</u> Incident Date(s) |
| 20. Hospital Name   | and address                          |
| 21. Date of Admittance  |                                      |
| 22. Plaintiff's Counsel Name  | 23. Plaintiff's Counsel Phone Number |
| 24. Plaintiff's Counsel Address                                       |                                      |

25. On the reverse/second page of this form, enter a comprehensive description or summary of the facts upon which each claim, charge or judgment rested including date of occurrence. Explain specifically whether death or personal injury occurred as a result of the negligence, error or omission in practice, or rendering of unauthorized professional services by the insured. Attach additional sheets as necessary. Photocopies of any pertinent documents which contain this information may be attached instead.

26. Case Resulted in: (Check one)  
☐ Settlement ☐ Judgment ☐ Arbitration Award

27. Date Resolved:

28. Total Amount of Award:  
 \$

29. Total Paid on Behalf of Physician:

30. Name and Location of Court/Arbitrator:

31. Filing Date:

32. Docket Number:

**\*\*\*\*PLEASE SEE REVERSE/SECOND PAGE OF FORM REGARDING MEDICAL RECORDS\*\*\*\***

I certify under penalty of perjury under the laws of the State of California that to the best of my knowledge the information provided within this report and any attachments is true and correct.

Signature of Preparer

Date

**REVERSE/SECOND PAGE-REPORT OF SETTLEMENT, JUDGMENT OR ARBITRATION AWARD**

11. (Continued):

Provider's Name	License #	Specialty	Amount Paid	
				<input type="checkbox"/> Settlement <input type="checkbox"/> Judgment <input type="checkbox"/> Arbitration Award
				<input type="checkbox"/> Settlement <input type="checkbox"/> Judgment <input type="checkbox"/> Arbitration Award

25. (Continued):

Enter a comprehensive description or summary of facts, describing the specific complaint or allegations of negligence or misconduct by the provider which resulted in the filing of the malpractice claim. Provide specific time frames and indicate if a death occurred.

\*\*\*\*PLEASE NOTE: California Business & Professions Code Section 801.01 (h)(3) requires every professional liability insurance carrier that submits this report to provide with the report copies of the records (including x-rays, ultrasounds, MRIs, CT scans, etc.) and depositions.

Records included ☐ Yes ☐ No (if not, please provide reason):